EXHIBIT A

MEDICAL RECORDS AUTHORIZATION

Re: Name: **MS. FLAVIA BENITEZ**
SSN # [redacted]
DOB: [redacted]

TO WHOM IT MAY CONCERN:

My name is **FLAVIA BENITEZ**. I hereby authorize the following persons, their employees, representatives, and agents, to contact any and all physicians, hospitals, clinics, pharmacies, psychiatrists, psychologists, therapists, or other providers of medical services or products, that have at any time examined, treated, or provided medical services or products to me:

Cooley Manion Jones LLP
21 Custom House Street
Boston, MA 02110

These persons are hereinafter referred to collectively as "THE AUTHORIZED RECIPIENT."

I further authorize said physicians, hospitals, clinics, pharmacies, psychiatrists, psychologists, therapists, or other providers of medical services or products to release to THE AUTHORIZED RECIPIENT all written, previously-created documents related to my physical or mental condition or the treatment given or services and products provided to me. This authorization specifically includes all paper documents, all medical "films" (MRI, X-ray, CT, sonogram, etc.) and associated reports, as well as all documents received by one provider of medical services or products from another provider of medical services or products, so-called "re-release" or "re-disclosure."

I retain the right to revoke this authorization with respect to any medical provider by conveying a written statement of revocation to any medical provider pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No 104-191, and 45 C.F.R. §164.508(c).

A copy of this authorization will serve as an original and will remain in full force and effect for a period of one (1) year from the date of this authorization, or until written notification is given by me revoking same.

Signed on _____ 2006.

_____
FLAVIA BENITEZ

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